HEALTH INSURANCE PROGRAM FOR MICHIGAN APPLICATION

SECTION 1. Instructions

1. Complete the application in black or blue ink.
2. Answer all questions completely. Incomplete applications may delay the eligibility determination process.
3. Choose a Plan option
4. Sign and date the completed application.
5. Review the "check list" (section 10) at the end of this application to ensure you provided all of the required information for PHP to review and process your application.

SECTION 2. Applicant Information

Last Name	First	Middle	Gender	Telephone Number
			M ☐ F ☐	( ) -
Street Address	City	State	ZIP Code	Date of Birth (MM/DD/YY)
Social Security Number	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Widower			
Email Address:				

SECTION 3. Enrollment Information

Please answer "yes" or "no" to the following questions, and list any pre-existing conditions.

1. Are you a resident of the State of Michigan?..... ☐ Yes ☐ No
2. Are you employed?..... ☐ Yes ☐ No
   2.a If so, does your employer offer coverage?..... ☐ Yes ☐ No
   2.b If so, are you eligible for coverage?..... ☐ Yes ☐ No
3. Are you eligible for coverage under your spouse's employer?..... ☐ Yes ☐ No
4. If you are under the age of 26, are you eligible for insurance by a parent?..... ☐ Yes ☐ No
5. Have you been uninsured for at least 6-months?..... ☐ Yes ☐ No
6. What was the last date you had insurance coverage?..... ___/___/_____
7. Why did you lose that coverage?_____
   _____
8. Have you tried to get other coverage? ..... ☐ Yes ☐ No
9. Are you a U.S. Citizen or national of the United States, or lawfully present in the U.S.? ☐ Yes ☐ No
10. For health reasons, has a carrier refused to issue creditable coverage within the previous 6-months?..... ☐ Yes ☐ No

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SECTION 4. Information about Your Medical Condition or Diagnosis

Please check the box that applies to you:

- ☐ **I have a medical condition, disability, or illness, or I had a medical condition, disability, or illness in the past.**
  - **NOTE:** You must provide a copy of a letter from a doctor, physician assistant, or nurse practitioner dated within the past 12 months stating that you have or had a medical condition, disability, or illness. This letter must include your name and medical condition, disability, or illness and the name, license number, state of licensure, and signature of the doctor, physician assistant, or nurse practitioner.
- ☐ **I have been denied health coverage.**
  Because I have a medical condition, I received either a denial letter from an insurance company for individual insurance coverage (not health insurance offered through a job) in my state that is dated within the past 12 months, **or** I received a letter dated within the past 12 months for an insurance agent or broker licensed in any state that tells me that I am not eligible for individual insurance coverage from one or more insurance companies because of my medical condition.
  - **NOTE:** You must provide a copy of the insurance company's denial letter or a copy of the agent or broker's letter.

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SECTION 5. Information about Other Coverage

To be eligible for this coverage, you must have been without other health coverage for at least 6 months from the date of this application. At any point in the **past 6 months,** have you had any of the following types of coverage? You must answer each question.

Yes	No	
☐	☐	Medicare (Part A and/or Part B)?
☐	☐	Medicaid?
☐	☐	Children's Health Insurance Program? (MIChild)
☐	☐	A group health plan that includes benefits that constitutes creditable coverage, or COBRA benefits?
☐	☐	Individual Health Coverage?
☐	☐	TRICARE (military health insurance)?
☐	☐	Health coverage provided by a public health plan established by a state, the U.S. government such as coverage provided to veterans enrolled in VA health care or foreign country?
☐	☐	FEHBP (health insurance for Federal employees or retirees), including Temporary Continuation of Coverage (TLC)?
☐	☐	Health benefit plan provided to Peace Corps workers?
☐	☐	Services provided by the Indian Health Service or by a Tribe or Tribal organization for treating your medical condition?
☐	☐	Services through a Michigan County Health Plan?

SECTION 6. Employer Information

PHP will contact any employers listed on this application for the purpose of verifying employment and insurance information.

Employment Status: ☐Employed Full-Time ☐Employed Part-Time (Hours/week) _____ ☐Self Employed ☐Unemployed	
Does your employer offer health coverage? ☐Yes ☐No	
If yes, why are you not covered on your employer-sponsored health coverage?	
Employer Name	Employer Address/Phone number
Spouse Employer Name	Spouse Employer Address/Phone number

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SECTION 7. AGE SPECIFIC RATES and HIP PLAN OPTIONS

HIP for Michigan offers three (3) plan options which are summarized below. Your application cannot be processed if you do not choose a plan.

AGE	PLAN 1	PLAN 2	PLAN 3
Children 0-18	$171.63	$123.57	$103.83
19 – 24	171.63	123.57	103.83
25 – 29	210.65	151.67	127.44
30 – 34	238.00	171.36	143.99
35 – 39	254.01	182.89	153.68
40 – 44	273.92	197.22	165.72
45 – 49	315.11	226.88	190.64
50 – 54	393.38	283.23	237.99
55 – 59	514.89	370.72	311.51
60 +	514.89	370.72	311.51
Payment Maximums:			
Annual Deductible	$1,000.00	$2,500.00	$3,500.00
Annual Maximum of Deductible and Co-Insurance	$2,500.00	$4,000.00	$5,000.00
Total Annual maximum for deductible, co-insurance and co pays.	$5,950.00	$5,950.00	$5,950.00

Please select only one (1) HIP for Michigan plan:

X PLAN 1: ($1,000.00 Deductible)
(Lowest deductible, highest premium)

☐ PLAN 2: ($2,500.00 Deductible)
(High deductible, low premium)

☐ PLAN 3: ($3,500.00 Deductible)
(Highest deductible, lowest premium)

*Note: All covered benefits are the same in each plan you choose. Only the annual payment maximums and the monthly premium payments you are responsible for vary with each plan.

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SECTION 8. Verifying Your Understanding of this Application and Signing It.

1. I understand until HIP Michigan approves my application and the full amount of the first month's premium is paid, I understand no coverage will be effective.
2. I understand that I have subject to disenrollment and possible prosecution to the extent allowable under state and federal laws if this information is false, fraudulent, or contains intentional misrepresentation of a material fact.
3. I understand it is my responsibility to inform HIP Michigan of any changes that may affect my eligibility, including any health insurance coverage that I may get in the future.
4. I understand that, if I move out of the HIP Michigan service area, I must notify HIP Michigan so that I can disenroll.
5. I understand that if I voluntarily disenroll from HIP Michigan or if I am disenrolled involuntarily (for example, for failure to pay my premium on time), I may not re-apply for enrollment until at least 6 months after my coverage ends.
6. I understand and agree to allow HIP Michigan to contact any employers and insurers listed on this application for the purpose of verifying employment and insurance information.
7. I understand that I am responsible for all medical costs of services not covered by HIP Michigan.
8. I understand that a medical examination may be required to determine whether I am eligible for coverage.
9. I understand that, by signing below, I certify that all information and documents provided as part of this application for coverage is complete, accurate, and true to the best of my knowledge and belief.

Signature	Today's Date

If you are a parent or legal guardian or an authorized representative of the person applying for coverage, you must sign above and provide the following information:

Full Name		Telephone Number with Area Code
Mailing Address		
City	State	Zip Code

Check Your Relationship to the Person Applying for Coverage:

☐ Parent	☐ Authorized Representative	☐ Legal Guardian

Refer to the Checklist section 9 to make sure your application is complete.

NOTE: Upon receipt of your application, you will receive a confirmation letter from PHP within 10 business days from the date your application has been received. Contact PHP Customer Service at 1.877.459.3113 if you do not receive a confirmation letter within the 10 days.

SECTION 9. How You Heard about HIP Michigan (Optional)

Please tell us how you heard about HIP Michigan (Check All That Apply).
Completing this section of the application is optional.

- ☐ Family Member or Friend
- ☐ Coworker or Colleague
- ☐ Mail Solicitation
- ☐ Internet Search
- ☐ Internet Article
- ☐ Radio
- ☐ Television
- ☐ Publication (newspaper, magazine or journal)
- ☐ Healthcare Provider
- ☐ Insurance Company
- ☐ Insurance Broker
- ☐ Public Event
- ☐ Other

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SECTION 10. Checklist for Submitting Your Application

You must provide copies of the following information with your application.

Michigan Residency: all applicants

- ☐ MI Driver License, or
- ☐ MI State Identification Card

Citizenship or Lawful Presence Verification: all applicants

Citizenship:

- ☐ Birth Certificate indicating U.S. as birth nation or

Lawful Presence Verification: any one or combination of: where applicable

- ☐ I-327 (Reentry Permit)
- ☐ I-551 (Permanent Resident Card)
- ☐ I-571 (Refugee Travel Document)
- ☐ I-766 (Employment Authorized Card) accompanied by either the I-94 and an Unexpired Foreign Passport or an I-797 (Notice of Action)
- ☐ Machine Readable Immigrant Visa (with Temporary I-551 Language) affixed to Unexpired Foreign Passport
- ☐ Temporary I-551 Stamp (on passport or I-94) affixed to I-94 or Unexpired Foreign Passport
- ☐ I-94 (Arrival/Departure Record) with Unexpired Foreign Passport
- ☐ Unexpired Foreign Passport
- ☐ I-20 (Certificate of Eligibility for Nonimmigrant (F-1) Student Status) accompanied by I-94 and Unexpired Foreign Passport
- ☐ DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status) accompanied by I-94 and Unexpired Foreign Passport
- ☐ Other Document with an I-94 or Alien Number

Medical Condition:

- ☐ A copy of a letter from a doctor, physician assistant, or nurse practitioner dated within the past 12 months stating that you have or had a medical condition, disability, or illness. This letter must include your name and medical condition, disability, or illness and the name, license number, state licensure, and signature of the doctor, physician assistant, or nurse practitioner, or
- ☐ Notice of rejection of coverage from an insurer if you have been rejected by an insurer for any other health reason or broker's letter within the last 12 months

Plan Choice:

- ☐ Check a plan you want under section 7

Mail your application, premium payment for the plan you choose and required documentation to:

PHP-HIP Michigan
Enrollment Department
P.O. Box 30377
Lansing, MI 48909-7877

If you have questions about this application, call PHP Customer Service at 1.877.459.3113.

CSHCS Clients: Mail application and required documentation to:
MDCH-CSHCS
P.O. Box 30734
Lansing, MI 48909-9852